City of Menasha

HEALTH ACCOUNT REIMBURSEMENT REQUEST FORM

Complete the information below for expenses incurred by you, and dependents for which you are requesting reimbursement. You must provide itemized documentation of each expense or have the provider sign in the Provider's Signature box on this form. Always retain copies of the Reimbursement Request Form and documentation for your own records.

Please submit requests to:
The Horton Group/HCSC Division
N19 W24101 N. Riverwood Drive
Waukesha, WI 53188
OR
Fax this form and all documents to 262.347.2709

For additional information call: 866.218.6063 OR 262.347.2609

Be sure to provide all information requested on this form, or the form will be returned to you.

EMPLOYEE INFORMATION

SOCIAL SECURITY #:

EMPLOYER: **City of Menasha**

PARTICIPANT:

ADDRESS:

CITY/STATE/ZIP:

DAYTIME PHONE NUMBER:

Is this an address change? Yes_____ No _____

You must also notify your employer of any address changes.

YOU MUST SIGN THIS FORM BELOW

HEALTH CARE EXPENSES

PROVIDER OF SERVICES (Doctor, dentist, clinic)	Date of Service (MO/DAY/YR)	Amount of Expense	Nature of Expense (description in detail)	Office Use Only
Total Requested Amount		$		

I request reimbursement from my health care expense account as indicated above. **I certify that these expenses are not eligible for reimbursement under any other plan and comply with the requirements of this plan.** I have not and will not claim these expenses for tax credit or deduction purposes on my income tax return. **Always retain a copy of the Reimbursement Request Form and originals of the documentation for your own tax records.**

PARTICIPANT SIGNATURE X_____